TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GABRIEL JASSO PHD

MFDR Tracking Number
M4-17-1944-01

MFDR Date Received
February 23, 2017

Respondent Name
BEXAR COUNTY

Carrier's Austin Representative
Box Number 29

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is a balance of 602.90."

Amount in Dispute: $3,033.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation a recommendation is being made in the amount of $2430.70 including interest. A copy of the EOB is attached."

Response Submitted by: IMO

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
October 5, 2016	96119 x 20	$3,033.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
3. 28 Texas Administrative Code §133.308 sets out the procedure for resolving medical necessity disputes.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
5. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12 – Workers compensation jurisdictional fee schedule adjustment

Issues

1. Did the insurance carrier issue a payment for disputed CPT Code 96119 x 20 units?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks additional reimbursement for CPT Code 96119 rendered on October 5, 2016. Review of the insurance carrier's position contained copies of EOBs supporting that a payment was issued after the filing of the medical fee dispute. The insurance carrier paid the requestor $2,410.60 for CPT Code 96119 x 20 units. The requestor seeks an additional payment of $602.90 for the disputed service.

   28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 96119, service date October 5, 2016, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.55 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.55. The practice expense (PE) RVU of 1.69 multiplied by the PE GPCI of 0.92 is 1.5548. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.822 is 0.01644. The sum of 2.12124 is multiplied by the Division conversion factor of $56.82 for a MAR of $120.53 at 20 units is $2,410.60.

   The division finds that the insurance carrier issued a payment in the amount of $2,410.60 for the disputed service. As a result, the requestor is not entitled to an additional payment of $602.90.

2. Review of the submitted documentation finds that the insurance carrier paid the fee schedule amount of $2,410.60 for CPT Code 96119 x 20 units. As a result, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 28, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.